

**Remember Clinical Advice Line for any support in decision making: 01234 779203** Please also refer to JRCALC Emergency Birth in the Community.

**Maternity Action Card**

**ANTEPARTUM HAEMORRHAGE Cont’**

***Placenta NOT delivered***

* Consider use of Misoprostol 800mcg - refer to JRCALC. Caution: Misoprostol is contraindicated in possible multiple pregnancy/known or suspected fetus in utero/potential concealed pregnancy
* Time critical with pre-alert nearest obstetric unit
* Obtain IV access and commence fluids as required
* For ongoing bleeding administer TXA 1g IV
* Time critical transfer with pre-alert nearest obstetric unit

***Placenta delivered***

* Perform uterine massage and offer Entonox
* Consider use of Misoprostol 800mcg - refer to

JRCALC

* Encourage mother to empty bladder
* Obtain IV access and commence fluids as required
* For ongoing bleeding administer TXA 1g IV
* Time critical transfer with pre-alert nearest obstetric unit

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**24 hrs to 12 weeks postnatal** *Consider Retained placenta? Sepsis?*

* Time critical with Pre-alert Nearest ED
* IV access en-route

**MANAGE HAEMORRHAGE IMMEDIATELY**

**ANTEPARTUM HAEMORRHAGE**

***<20 weeks - Consider***

* *Referred pain to shoulder, ectopic, miscarriage?*
* Time critical requiring pre-alert nearest ED?
* IV access en-route & O2 15l/min

***>20 weeks - Consider***

* *Constant abdo pain, back pain, placental abruption, placenta praevia?*
* Time critical requiring pre-alert nearest obstetric unit
* Left lateral positioning
* IV access en-route & O2 15l/min

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**Postpartum Haemorrhage (PPH)** - Immediatelyafter birth blood loss more than 500ml

*Consider 4 T’S – Tone, Trauma, Tissue, Thrombin*

*Uterine atony? Vaginal tear? Retained placenta?*

*Clotting problems?*

**3rd STAGE**

* Placenta may take up to 1 hr to deliver DO NOT pull cord
* Encourage mother adopt squatting/standing position
* Keep woman warm, comfortable and close to baby
* Encourage the woman to empty bladder to facilitate uterine contraction
* Deliver placenta into plastic bag for midwife inspection
* Assess and record estimated blood loss (should not exceed 200-300mls) TIME PLACENTA DELIVERED…………........
* If placenta not delivered in 20 mins insert large bore IV as increased risk of bleeding & may require fluids
* If placenta remains undelivered with minimal bleeding transfer to nearest appropriate destination
* Placenta still undelivered & bleeding? Refer to PPH guidance
* Maternal safety is the prime concern
* Rapid transfer with pre-alert to nearest appropriate destination
* Consider specific clinical situation and which interventions may be required for the woman and baby on arrival
* **Consider Safeguarding concerns FGM, concealed pregnancy, visual inspection of birth products**

**Normal Birth**

**UNDERTAKE PRIMARY SURVEY**

* Establish gestation & frequency of contractions - look for waters broken/show and/or bleeding

**BIRTH IMMINENT**

* Regular contractions 1-2 mins- urge to push-crowning. Request Midwife
* Prepare for newborn life support – maintain warm environment
* Reassure woman and support in a comfortable position- avoid supine position
* Provide Entonox for pain relief
* Allow baby’s head to be born encourage woman to pant/breathing out during birth
* Consider applying gentle pressure to the top of the baby’s head to prevent very rapid birth of the head.
* If umbilical cord around neck it does not require removal as baby can be born with cord left in place
* Support baby during birth & place on mother’s abdomen- wipe any mucus from baby’s mouth & nose. NOTE TIME OF BIRTH……….
* Thoroughly dry baby with a warm towel, wrap with dry towel and put on hat- whilst undertaking ABCD assessment. With tactile stimulation baby should breath spontaneously within 60 secs
* If baby crying provide ‘skin-to-skin’ contact with mother. Allow breast feeding
* Allow umbilical cord to stop pulsating prior to clamping & cutting
* IF BABY NOT CRYING refer to NEWBORN LIFE SUPPORT as per JRCALC

|  |  |  |  |
| --- | --- | --- | --- |
| APGAR must | | Be Recorded | @ 1& 5 mins |
| Score 0 | | 1 | 2 |
| A | Limp, no movement | Some flexion in arms and legs | Active motion |
| P | No Heart rate | <100 BPM | >100 BPM |
| G | No response to stimulus | Grimace during stimulation | Grimace and pulling away from stimulation |
| A | Whole body blue or pale | Centrally pink but peripheral cyanosis | Good colour all over body |
| R | No breathing | Weak cry, slow or irregular breathing | Strong cry, normal rate and effort of breathing |

Keep baby warm, dry and preferably skin to skin.

**CORD MANAGEMENT**

DO NOT clamp and cut the umbilical cord until it has stopped pulsation Remember WAIT FOR WHITE. This should take 10-20 minutes.

Once pulsation has stopped or the placenta has delivered can the cord be cut.

Apply two cord clamps securely 3cm apart and about 15cm from the umbilicus. Cut the cord between the two clamps. CAUTION ensure the newborn’s fingers and genitals are clear of the scissors.

ONLY exceptions for early clamping:

* Cord snapping
* Newborn life support required where it is not possible with the cord intact.
* Refer to Newborn Life Support algorithm as per JRCALC/clinical app

**Newborn Management**

To ensure the best outcome, both physiologically and emotionally consider factors that facilitate hormone production, calm, dimly lit, dignified environment and ensure the women is reassured and informed at all times.

All incidences apart from normal birth of baby and placenta require transfer to obstetric unit not midwife led.

If the baby is born in poor condition (initial APGAR 5 or less) then record the time of regular respirations and transport immediately

Record continuous APGAR scores until the care is handed over to receiving team.

**Cord Prolapse**

1. In ambulance convey in exaggerated left/right lateral position with hips elevated and blanket between legs, but ensuring still restrained in 4 point harness.

**DO NOT** transport in knee chest position

6. Pre-alert & rapid transport to nearest consultant lead obstetric unit.

1. Mother adopts knee chest position with head on forearms (in home), while waiting until ready to walk to ambulance
2. Encourage mother to replace the cord into the vagina, if will not reinsert, do not manipulate
3. Protect the cord with **dry** dressing or underwear
4. Walk mother rapidly to ambulance – If nearby. **DO NOT** use carry chair

A person lying on the floor

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**BREECH – Request Midwife**

A person holding a baby

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**Warm the area – Prepare for newborn resus** Mother turned onto all fours

1. “**Hands Off**” and allow body to hang.

Observe for progress

1. Keep ‘**Baby’s tum to mums bum**’ so the baby’s abdomen is always visible, keep mum in all fours
2. Encourage pushing with contractions, if slow progress occurs, encourage movement in the hips, as well as squatting backward onto the heels to increase pelvic dimensions

**DO NOT** support the baby, allow it to hang, **remember hands off!!**

**DO NOT** Clamp or Cut the cord during birth

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**Undelivered?** Apply **Continuous Suprapubic Pressure** –attempt delivery for 30 seconds

**Undelivered?** Apply **Rocking Suprapubic Pressure** –Attempt delivery for 30 seconds

**Undelivered?** Position mother on **ALL FOURS** -Attempt delivery for 30 seconds

**Undelivered?** – Walk to ambulance - pre-alert to nearest obstetric unit- convey in lateral position

**Record time of delivery of head and time of delivery of baby**

**Warm the area – Prepare for newborn resus**

Baby not born after two contractions following birth of the head?

Position Mother into **McRoberts Position** - Hyperflex legs then attempt delivery using gentle axial traction for the next 30 seconds

**SHOULDER DYSTOCIA – Request Midwife**